

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155616</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/21/2016</b>	
NAME OF PROVIDER OR SUPPLIER  <b>NEW ALBANY NURSING AND REHABILITATION CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 E ELM ST</b> <b>NEW ALBANY, IN 47150</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00197461 and IN00195780.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on March 10, 2016.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaint IN00195157 completed on March 10, 2016.</p> <p>Complaint IN00197461 - Unsubstantiated due to lack of sufficient evidence.</p> <p>Complaint IN00195780 - Unsubstantiated due to lack of sufficient evidence.</p> <p>Survey dates: April 20 and 21, 2016.</p> <p>Facility number: 001145 Provider number: 155616 AIM number: 200120200</p> <p>Census bed type: SNF/NF: 81 Residential: 16 Total: 97</p> <p>Census payor type: Medicare: 3 Medicaid: 53 Other: 15 Total: 81</p> <p>New Albany Nursing and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155616</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/21/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>NEW ALBANY NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 E ELM ST</b> <b>NEW ALBANY, IN 47150</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 the Investigation of Complaints IN00195780 and IN00197461.  Quality review completed by 34233 on April 27,2016.	F 000			